



**Virginia Department of Mental Health, Mental Retardation,
and Substance Abuse Services**
RENEWAL PROVIDER APPLICATION FOR LICENSING

SECTION 1: Renewal Applicant Information: Identify the person, partnership, corporation, association, or governmental agency applying to lawfully establish, conduct, and provide service:

Organization Name: _____

Mailing Address _____

City: _____ County _____ State: _____

Zip: _____ Phone: () _____

Chief Executive Office or Director. Identify the person responsible for the overall management and oversight of the service(s) and facility(s) to be operated by the applicant.

Name: _____ Title: _____

Phone: () _____ Fax Number: () _____ Email: _____

****Please review the addendum's "licensed as" statement for accuracy in the descriptions of services. If any are inconsistent with the actual service, please note the discrepancy on the addendum and send a copy of the current service description with your application.**

SERVICE INFORMATION

Please circle the currently licensed services you are seeking to renew. If the service type(s) is not listed, please note in the service information section.

- | | |
|--|--|
| <p>* Residential Services
Community ICF-MR
Community Gero-psychiatric
Crisis Stabilization
Group Home
Half-Way House
Medical Detox and Social Detox
Residential Community Services
Residential Respite
Residential Treatment
Residential Treatment SA women w/children
Supervised Living</p> <p>* Day Support Services
Clubhouse
Day Support
Day Treatment
Intensive Outpatient
Partial Hospitalization/Ambulatory Detox
Psychosocial Rehabilitation
Therapeutic After-School
Center-Based Respite</p> | <p>* Supportive In-Home Services (formerly supportive residential)
In-Home Services
In-Home and Out-of home Respite
Mental Health Community Support Services
Crisis Stabilization</p> <p>* Case Management Services</p> <p>* Inpatient Services
Psychiatric Unit
Medical Detox/CD Unit</p> <p>* Intensive In-Home Services</p> <p>* Opioid Treatment Services</p> <p>* Outpatient Services
Outpatient
Emergency</p> <p>* Sponsored Residential Home Services</p> <p>* Department of Corrections Facilities Services</p> <p>* Intensive Community Services (ICT)</p> <p>* Programs for Assertive Community Treatment (PACT)</p> |
|--|--|

SECTION 2: Service Information: Use space below to identify any corrections and effective date of change for each

service/location licensed by the Department of Mental Health, Mental Retardation and Substance Abuse Services.
(See attached for listing of services types)

Service Type: _____

Service Director: _____ Phone: () _____

THIS SERVICE SERVES:

Individuals with single diagnosis (check all that apply):

AND/OR

Individuals with multiple diagnoses (check all that apply):

☐ Mental Retardation

☐ Mental Illness/Mental Retardation

☐ Mental Illness

☐ Mental Retardation/Substance Abuse

☐ Substance Abuse

☐ Mental Illness/Substance Abuse

☐ Mental Illness/Mental Retardation/Substance Abuse

☐ Individuals receiving services through the Individual and Family Developmental Disabilities Support Waiver

Individual Demographics (check all that apply):

☐ Male

☐ Female

☐ Child

☐ Adolescent

☐ Adult

☐ Geriatric

Accreditation/Certification by: _____

Location(s)

1. **Location Name:** _____ **License #:** _____ **# of beds:** _____

Address: _____

City: _____ **County** _____ **State:** _____ **Zip:** _____

Location Manager: _____ **Phone:** () _____

Directions: _____

2. **Location Name:** _____ **License #:** _____ **# of beds:** _____

Address: _____

City: _____ **County** _____ **State:** _____ **Zip:** _____

Location Manager: _____ **Phone:** () _____

Directions: _____

3. **Location Name:** _____ **License #:** _____ **# of beds:** _____

Address: _____

City: _____ **County** _____ **State:** _____ **Zip:** _____

Location Manager: _____ **Phone:** () _____

Directions: _____

Note: If there are additional locations please photocopy additional sheets as needed.

SECTION 3. Certificate of Application

This Certificate of Application is to be read and signed by the applicant. The person signing

below must be the individual applicant in the case of a proprietorship or partnership, or the chairperson or equivalent officer in the case of a corporation or other association, or the person charged with the administration of the service provided by the appointing authority in the case of a governmental agency.

I am in receipt of and have read the applicable rules and regulations for licensing. It is my intent to comply with the statutes and regulations and to remain in compliance if licensed.

I grant permission to authorized agents of the Department of Mental Health, Mental Retardation and Substance Abuse Services to make necessary investigations into this application or complaints received I understand that unannounced visits will be made to determine continued compliance with regulations.

TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL INFORMATION CONTAINED HEREIN IS CORRECT AND COMPLETE. I FURTHER DECLARE MY AUTHORITY AND RESPONSIBILITY TO MAKE THIS APPLICATION.

Signature of Applicant: _____ Date: _____

Title: _____

If you have any questions concerning the application, please contact this office at (804) 786-1747. This application is to be returned within 30 days to:

**Office of Licensing
Department of Mental Health, Mental Retardation and Substance Abuse Services
Post Office Box 1797
Richmond, Virginia 23218-1797
<http://www.dmhmrsas.state.va.us>**